San Francisco Chronicle

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To the Anthony Shadid Award Committee:

Gov. Gavin Newsom was extolling his career-defining overhaul of California's mental health care system when San Francisco Chronicle reporters Joaquin Palomino and Cynthia Dizikes received a harrowing tip.

The governor had spearheaded legislation to build new behavioral health facilities and force more people into treatment, selling the moves on the national stage as a solution to California's crushing homelessness crisis.

Yet the San Francisco man who contacted the Chronicle said that instead of receiving help for a severe manic episode, he had been forcibly locked inside a psychiatric hospital operated by a for-profit company where other patients beat and raped him. The police reports he filed went nowhere. Lawyers weren't interested.

"The message I am getting from society is that, if you are mentally ill, nobody cares what happens to you," he wrote. "If I were the only one who experienced these horrors, I would likely give up and try to move on with my life. But I am not. … Please help us."

The appeal would lead to "Failed to Death," a four-part investigation by Dizikes and Palomino, which revealed in undeniable terms how California officials had disregarded state law in their race to open more treatment beds, allowing rampant violence and deadly neglect to overrun facilities meant for healing.

From the outset, Palomino and Dizikes had to navigate myriad ethical considerations as they sought to pull the curtain back on the rapid growth of for-profit psychiatric hospitals in California through accounts from patients traumatized by their time inside these facilities and surviving family members still in grief.

The reporters proceeded with a principle of doing no harm, even as the articles required them to describe the harm inflicted on patients in great detail. When first connecting with former patients, or families, reporters wrote emails and letters, rather than cold-calling, to give them time to decide if they wanted to talk. For those who did, Dizikes and Palomino offered to do so in whatever setting felt safest. When patients had support people they wanted to include, the reporters welcomed them into the process and started all conversations off-the-record, reminding patients there was no obligation to share any personal information.

Reporters spent more than a year traveling the state and sitting with patients and their families, who described arriving at these hospitals in hopes of recovering from emotional crises, only to endure the worst moments of their lives. As Palomino and Dizikes began drafting, they talked with sources for hours about whether they were comfortable being included, given the potential implications for them, including the strain on their mental health. For those who chose to move forward, reporters reviewed all relevant details in context and provided anonymity when requested, including to survivors of sexual abuse, while still rigorously corroborating their accounts.

For their first story, reporters reached out to the mother of 15-year-old Jázmin Pellegrini after reading breaking news of the teenager's death. Palomino and Dizikes had noticed a reference to Jázmin's mental health struggles, and that she had reported being sexually abused at a for-profit psychiatric hospital in the Bay Area. Jázmin's mother, who had immigrated to the United States from Hungary and primarily spoke Hungarian, told reporters she wanted the public to know just how badly California's mental health care system had failed her daughter. But she was still in shock.

To ensure clear communication, the Chronicle hired a professional interpreter who Jázmin's mother was comfortable with to help reporters fully explain their process. The interpreter assisted in obtaining Jázmin's medical records, getting HIPAA releases signed to allow experts to review those documents and provide insights, and translating months of interviews. Reporters included Jázmin's mother on the expert feedback throughout their reporting.

Some of the most serious incidents in psychiatric hospitals involved self-harm. When describing these events, reporters had to carefully consider their obligation to expose negligent care without being overly descriptive in ways that could increase the risk of suicide for other vulerable people.

This balance came into sharpest focus in their second story when reporters detailed Tyler Thatcher Cox's suicide in a San Diego psychiatric hospital after employees failed to check on him for hours. Dizikes and Palomino had to weigh what to include in the article text, as well as what, if anything, to include from hospital surveillance footage that Tyler's family provided to the Chronicle, which had captured his death.

After extensive discussions with Tyler's family as well as top Chronicle editors, and others in the newsroom, the reporters only included details relevant to the hospital's inadequate care without describing specifically how Tyler had completed suicide.

Similarly, the Chronicle limited the surveillance footage it published to a few key moments that help readers connect to Tyler, as a person, and show the room where he died — and its close proximity to caregivers who should have seen him.

Palomino and Dizikes also built the most comprehensive dataset to date of the harm that patients have reported experiencing in for-profit psychiatric hospitals, which became the foundation for much of the series.

A very small fraction, or just several of some 300 incidents, involved facilities unsafely discharging patients, who then harmed other people. Some had grabbed headlines at the time they occurred. But

reporters chose not to spotlight them unless they were directly relevant to the failures they had uncovered in order to avoid sensationalizing their findings and furthering inaccurate stereotypes about mental illness.

Experts around the country recognized the attention the Chronicle gave to these difficult issues. "Your reporting has had a remarkable impact and is so important right now given the state's investments in inpatient care (and the broader pendulum swing toward hospitalization)," a top advocate with the California Health Care Foundation wrote to reporters after the series was published. "I know from our earlier correspondence just how long and carefully you've been working on this. It's heartening to see that the Chronicle still supports this kind of journalism."

Most significantly, patients and their family members said they were grateful their experiences were finally heard. "She will be happy that people are doing something for her," Jázmin's mother told reporters. "To see her as she really was."

Days after the second story was published, lawmakers demanded answers from top health officials about the "catastrophic treatment" the Chronicle had exposed in for-profit psychiatric hospitals, including the state's utter failure to take action when patients suffered grave harm, or to enact staffing standards explicitly required under state law. "As the State of California, we have failed," the head of the state Senate Health Committee said at a March hearing. "And as a result … people have died under our watch."

The following month, Newsom declared understaffing in psychiatric hospitals to be an emergency and deployed his health department to investigate numerous incidents detailed by the Chronicle. The state has since introduced the country's first minimum staffing mandates for psychiatric hospitals, while the health department has taken sweeping measures to better police these facilities by hiring more inspectors and issuing $1.8 million in penalties.

Without such careful, empathetic and exhaustive reporting, the magnitude of abuse and neglect inflicted upon patients seeking emergency mental health care in California — and the state's refusal to reckon with these deplorable conditions — would have persisted, unchecked and out of sight.

For their groundbreaking work that exposed vast harm within profit-driven psychiatric hospitals, and forced immediate reforms to better protect tens of thousands of patients every year, the San Francisco Chronicle is proud to nominate Joaquin Palomino and Cynthia Dizikes for the Anthony Shadid Award.

Emilio Garcia-Ruiz,
Editor-in-Chief, San Francisco Chronicle

Nominator: Ryan Gabrielson, Investigative Editor, (480) 223-3283, ryan.gabrielson@sfchronicle.com
Reporters: Joaquin Palomino, Cynthia Dizikes, jpalomino@sfchronicle.com, cdizikes@sfchronicle.com

Failed to Death

Nominator: Ryan Gabrielson, Investigative Editor, San Francisco Chronicle. Phone: (480) 223-3283, Email: ryan.gabrielson@sfchronicle.com

Reporters: Joaquin Palomino and Cynthia Dizikes, jpalomino@sfchronicle.com, cdizikes@sfchronicle.com

Primary story links:
To bypass our paywall, please use the following credentials:
User: generaluse@sfchronicle.com
Password: password1

2/26/2025: "The mystery shocked San Francisco. This is the story of the 15-year-old girl found dead in a driveway"
https://www.sfchronicle.com/projects/2025/california-psychiatric-hospitals-jazmin-pellegrini-death/
3/5/2025: "California is embracing psychiatric hospitals again. Behind locked doors, a profit-driven system is destroying lives"
https://www.sfchronicle.com/projects/2025/california-psychiatric-hospitals-crisis/

Additional installments:

12/29/2025: "'This business killed my son': A California hospital empire rises as patients suffer"
https://www.sfchronicle.com/projects/2025/california-signature-psychiatric-hospitals/
3/19/2025: "Violence and neglect plague a Bay Area psychiatric hospital. California has left its patients in danger"
https://www.sfchronicle.com/projects/2025/california-psychiatric-hospitals-patients/

Impact stories:

4/29/2025: "Newsom moves to set emergency staffing rules in psychiatric hospitals following Chronicle investigation"
https://www.sfchronicle.com/california/article/psychiatric-hospital-staffing-newsom-20294570.php
6/13/2025: "State weighs psychiatric hospital staffing standards after Chronicle investigation"
https://www.sfchronicle.com/california/article/psychiatric-hospital-regulation-20364883.php
12/29/2025: "California health officials unveil draft staffing rules for psychiatric hospitals in response to Chronicle investigation"
https://www.sfchronicle.com/california/article/state-officials-unveil-staffing-rules-psychiatric-21263142.php
12/31/2025: "California toughens oversight of for-profit psychiatric hospitals, enacts 'historic' staffing rules in response to Chronicle investigation"
https://www.sfchronicle.com/california/article/psychiatric-hospital-health-california-21248198.php